Return Application With Check Payable To:
Treasurer – State of NH

Annual Licensing Fee:
$150

State of New Hampshire
Board of Pharmacy

121 South Fruit Street
Concord, NH 03301-2412
Tel.: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy

Board Use Only (Do Not Write In This Box)

July 1, 2014 – June 30, 2015
Registration Period

LIMITED RETAIL DRUG DISTRIBUTOR
PUBLIC HEALTH CLINIC

UNDER CONTRACT WITH THE NH DIVISION OF PUBLIC HEALTH SERVICES

Clinic Name & Address: ***(Actual Licensed Location)***

_____
Clinic Name

_____
Street Address

_____
City *State* *Zip Code*

Telephone:	Fax:	E-Mail Address (If Applicable):

Parent Company (If Applicable):

Clinic Specialty:
☐ Family Planning ☐ STD
☐ Other Please Specify:_____

Security:
Alarm Installed: ☐ Yes ☐ No

Applicant's Proposed Drug Activity: **(To bona fide patients of clinic only)**

☐ Administer (Non-Controlled Drugs) ☐ Dispense (Non-Controlled Drugs)

Licensure does not authorize the receipt, storage or dispensing of controlled substances.

Name Of Owner(s): (Indicate Individual, Partners, Etc. - If Corporation, Show Title Of Officers) Attach Additional Sheet If Necessary

Name	Address	Title
Name	Address	Title

Has registration or licensure granted to the applicant by any state or federal agency ever been suspended or revoked? ☐ **Yes** ☐ **No**
(If "yes", attach a detailed description).

Is the clinic currently under contract with the *NH Division of Public Health Services*? ☐ **Yes** ☐ **No ***
(If "no", attach explanation).

Does the clinic maintain a written copy of a drug dispensing protocol (per NH RSA 318:42, VII) ? ☐ **Yes *** ☐ **No**
(If "yes", enter date the protocol was approved by the Department of Health & Human Services?).

Provide the information below for the person responsible for the operation of the clinic: (The permit & future renewals will be directed to this person)

Name:	Title:	Tel. #:

Business Mailing Address:

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Provide name(s) of person(s) in charge of drug purchasing, dispensing records and security. **(Use Reverse Side If Necessary)**

ALL QUESTIONS MUST BE ANSWERED – INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT BOTH THE CONSULTANT PHARMACIST'S & THE CLINIC REPRESENTATIVE'S SIGNATURES WILL NOT BE ACCEPTED.

APPLICATION CONTINUED ON NEXT PAGE ↳

Medical Director of Clinic:		
Name	Address	Telephone Number

Practitioners: (Use Reverse Side If Necessary)			
Name:	Title:	Name:	Title:

Consultant Pharmacist:		
Name	**Signature (Applications without consultant's signature will be returned)**	NH License No.

Declaration And Signature By Clinic Representative:

I declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the permit herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State.

Signature: _____ Title: _____ Date: _____

(Responsible Party) ***(Indicate whether owner, partner, or officer of corporation)***

**** THE LICENSEE SHALL NOTIFY THE BOARD, IN WRITING, OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.***

Rev. 06/14